

# Errata

## Amendments to text and tables

- The values provided in Table 52 for the predicted costs and effects are discounted from age 10, and include 10 prior years of life undiscounted (page 91). Originally, discounting from age 10 was applied because it is the age at which the model commences and from which HPV infection rates are modelled, and in order to allow for future evaluations which assess screening in conjunction with vaccination (since routine vaccination occurs in 12-13 year old girls). However, in the current evaluation, no costs or differences in health outcomes accrue before the age of screening commencement, at 18 years. For clarity, we recalculated the results such that discounted costs and life years accrued over a lifetime beginning at age 18 (the youngest age at which women are screened, and therefore costs start to accrue). This change affects the absolute and incremental costs and life years, but the incremental cost effectiveness ratios are unaffected. The relationship between the test technologies is also unaffected. This change does not alter the calculated ICERs or conclusions of the economic evaluation but the following changes are noted:
  - The addition of the following sentence at the end of paragraph 1 under ‘Results of economics evaluation’ on page 89: ‘The discount rate was applied from age 18, the youngest age at which costs and effects begin to accrue.’
  - The replacement of text in the first sentence of paragraph 2 on page 90 from ‘1 h’ to ‘1.4 h’ and from ‘3 h’ to ‘4.4 h’
  - The replacement of the first sentence of paragraph 2 on page 92 to ‘The impact of the new technologies on average LYS in the population is 0.0002–0.0005 LYS, or approximately 1.4–4.4 h over a lifetime, when discounted at 5 per cent.’
  - The replacement of Table 52 Predicted costs, effects, and incremental cost-effectiveness ratios, by cytology test technology (page 91).

**Table 52 Predicted costs, effects, and incremental cost-effectiveness ratios, by cytology test technology.**

Strategy	Discounted lifetime costs (5% discount rate <sup>a</sup> )	Discounted life years <sup>b</sup> (5% discount rate <sup>a</sup> )	Incremental discounted life years (min) <sup>b</sup> compared with current practice	ICER vs current practice (\$ / LYS)	ICER vs next most cost-effective strategy (\$ / LYS)
Current practice (CC)	\$418.68	18.87175	–	–	–
Manual LBC (\$2.40 incremental cost)	\$438.34	18.87190	0.000156 (82)	\$126 315	\$126 315
Automated LBC	\$515.44	18.87224	0.000497 (261)	\$194 835	\$226 100
Manual LBC (\$10.90 incremental cost)	\$478.74	18.87190	0.000156 (82)	\$385 982	Dominated <sup>c</sup>

<sup>a</sup> Discounted at 5% starting from age 18 years <sup>b</sup> Discounted Life Years (or minutes) from age 18 <sup>c</sup> Strategy is said to be dominated as it is more expensive than a strategy with equal or greater effectiveness, in this case Manual LBC at the lower incremental cost

- The cost of the test technology was inadvertently omitted from the list of factors to which findings were sensitive in “Executive Summary” (page xiv) and “Conclusions”(page 106). In order to be consistent with the findings of the sensitivity analysis reported in “Results of Assessment” under the sub-heading “Sensitivity Analysis” (page 93), text under the heading “Economic considerations” on page xiv and text in the section “Cost-effectiveness” on page 107-8 should read as follows:

The findings are sensitive to assumed relative test accuracy, differences in the unsatisfactory smear rate, assumptions about disease natural history (particularly for high-grade regression and progression), the recommended screening interval, and the cost of the new technology.